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ABSTRACT

This manual details a cooperative adult English as a Second Language (AESL)/mental health project within an Asian community. Three groups of participants are described: the ethnic Chinese adult, the AESL staff, and the mental health staff. The description of each group is followed by questions to consider in assessing clients and staff when replicating this model of systematic collaboration between two community-based organizations. The manual goes on to discuss six specific project components: planning, staff training (workshops), student awareness, referral process, intake procedure, and case conferences. Specific materials provided include a chart of project phases, summaries of the material covered in the workshops, and a student questionnaire on mental health issues. Each component is described, an evaluation of it is provided, and questions/areas for consideration when replicating this model are identified. A conclusion summarizes the advantages of community-level collaborations and the requirements for effective collaboration. (YLB)

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INTRODUCTION

> A single woman, 26 years old, is in the middle of her first semester of Adult English as a Second Language class. She has been in the United States for just under a year. She was on the waiting list for English for approximately six months. At first her attendance was regular, her homework complete. Now after two months in class, her attendance has become sporadic. Her homework is rarely done. Her teacher learns from her that she is facing a major medical operation and wonders about its efficacy. Her parents are opposed to surgery; her brother and sisters are in favor.

As teachers, we must often contend with this scenario. An adult enters an education program with strong motivation and commitment. Outside factors block the student from continuing with her* studies. The effect? The student's progress slows down or she* drops out of the program. Either result damages the self-esteem of the adult learner.

The Quincy School Community Council's Adult English as a Second Language program was designed to address this type of situation. We believe that a supportive environment, advocacy by staff familiar with student problems, a bilingual/bicultural program, and a curriculum which directly addresses life issues confronting the immigrant can lead to increased self-esteem and learning ability.

The Director of the Department of Mental Health and Social Services of the South Cove Community Health Center has commented that clients who attend ESL classes at QSCC tend to show more therapeutic progress

* Because the majority of students in the AESL program under study are female, we have chosen to use the feminine pronouns. The decision to use pronouns in only one gender is made only for the purpose of simplicity. General statements refer to both male and female students.

than clients not in ESL. Similar observations have been made by other community-based organizations. Furthermore, QSCC students and teachers have noted that support from the mental health team has improved the learning environment. It was this theme of reciprocal support that led directors of both programs to initiate a formal collaboration.

This project was based on the following assumptions: teaching adult ESL requires an advocacy approach; the mental health staff and adult ESL staff should work closely and utilize an informal referral process; and the staff of both programs should understand the social adjustment, cultural, and survival needs confronting the community.

Our initial objectives for this program were: (1) to increase the competence of Adult ESL staff as teacher/advocates; (2) to increase student/client awareness and use of the Adult ESL program and of the mental health services; and (3) to provide a replicable model of systematic collaboration between two community-based agencies.

Advocacy in adult education is not a sideline: it is a critical component to all programs. Advocacy may be more pronounced in some programs than others, but we contend that elements of advocacy exist in all education programs. We believe that this is a key to providing a learning atmosphere conducive for learning.

This manual charts our project year. Although it details a cooperative AESL/mental health project within a specific Asian community, we believe that the materials used can be applied in other communities and that the results we achieved will inspire inventive collaborations.

THE PARTICIPANTS -
THE ETHNIC CHINESE ADULT

Early Chinese immigrants, comprised mainly of unskilled laborers from the Toisan province of China, had a homogenous background. The newest wave of immigrants, on the contrary, come from a variety of locations, includirg the People's Republic of China, Hong Kong, Vietnam, and Taiwan. Their backgrounds and cultural influences are diverse. Some, like the early immigrants, come with a dream of a better life in the "land of opportunity." Others come reluctantly to escape their war-torn country or other circumstances.

The language barrier causes much stress. Inability to speak English creates initial problems. Not knowing English means unemployment or underemployment, a change in family roles, isolation.

Immigrants who are professionals, skilled workers, business people, and shopowners in their homeland cannot get the same positions here. They either become unemployed or settle for low-paying, dead-end jobs in factories, restaurants, or warehouses. Many women work for low wages in the garment factories, while a majority of the men work extremely long hours in restaurants.

The traditional patriarchal family structure also changes. Men might find themselves taking care of children if no job is available. Women work in the garment factories to supplement, and in some cases to provide the only source of, family income. Family role changes take a great toll on the adult immigrant. Parents must now depend on their children to be interpreters and financial managers. Often the child isn't ready for this responsibility, and consequently shows tremendous resentment, guilt, and social isolation. It is frustrating for the parents who are no longer in control of certain situations. As children acquire fluency in English and American customs, the parent-child relationship becomes increasingly strained.

In dealing with this adjustment experience, mental health problems sometimes develop. Mental health studies have ranked the Chinese higher than other immigrants in the frequency and severity of depression. Further problems include adjustment reaction, anxiety, psychosomatic symptoms, gambling, substance abuse, marital discord, and parent-child conflicts. For some immigrants these problems will eventually become manageable. For those with less support, more serious problems are likely to develop.

Traditionally, problems of family members have always been resolved within the family. To reveal to others that there are problems (financial, social, marital, mental) is to bring shame and guilt to the family name. An individual's actions are seen to reflect on the whole family. For people willing to seek outside help, family associations and close friends are called upon; but this is a last resort. Other forms of outside help are infrequently and reluctantly used.

Although community services cannot resolve the social, economic, and political problems confronting the immigrant, they can help people develop better methods of dealing with their new environment. The fact

of underutilization of agency services by Chinese must not be used to serve the racist myth of the "model minority," i.e., that Chinese are an exemplary, self-sufficient group who do not need support services. Instead, Asian social service agencies must use their knowledge of cultural attitudes to make the services truly accessible.

TO CONSIDER - The Adult Population

A. What are the present conditions?

1. Economic	5. Political
2. Social	6. Educational
3. Ethnic	7. Class
4. Cultural	8. Sex

B. What is the population's attitude toward mental health? toward education?

C. What are the general strengths of the population?

D. What areas (or issues) would a similar project address?

THE PARTICIPANTS -
THE ADULT EDUCATION STAFF

Teacher-advocates and counselors of an adult education program are in a strong position to address the social adjustment issues of their students. In our case, they provide a vital transitional service to the Chinese community by offering English classes with a bilingual staff and curriculum.

The staff-designed curriculum addresses daily life and survival issues throughout its five-semester texts. Working with a problem-focused curriculum invites students to bring personal issues into the classroom.

The teacher and ESL counselor are often the first people outside the family to whom the student reveals social adjustment, cultural, and personal problems. In time, a support network evolves which includes the teacher-advocate, the adult ESL counselor, and other students. As the teacher presents English through life-focused issues, such as housing, repairs, and health care, the students acquire both English and survival skills. This process enables the adult student to resolve her own problems.

Teacher-advocates and counselors in the QSCC AESL program have come to the program with: (1) a sensitivity to community issues; (2) an awareness of problems and needs as adult learners and immigrants; and (3) bilingual skills in Cantonese and English.

Because of the developed background of our staff, staff training focused on developing the following additional competencies:

* This section discusses the "advocate" component of Adult ESL staff. General teacher competencies are not discussed.

1. awareness of cultural differences between student and staff;
2. knowledge and recognition of common psychological problems of Asian immigrants;
3. ability to deal with such problems through advocacy and referral;
4. skill in introducing students to the mental health department;
5. ability to develop an integrated service plan;
6. knowledge of services provided by the health center; and
7. ability to set limits on oneself as teacher/advocate and adult ESL counselor.

The Adult ESL staff, through a bilingual and bicultural approach to English and survival skills, becomes an integral part of the adult student's learning about English and American culture.

TO CONSIDER - The Adult Education Staff

A. What is the composition of the staff?
B. What competencies does the staff currently have?
C. What competencies will this project develop or provide?
D. What is the role of the staff in this project?

THE PARTICIPANTS -
THE MENTAL HEALTH STAFF

The mental health staff in the Chinese community must both provide outreach education to address the prevailing attitudes toward mental health and offer a therapeutic approach which is sensitive to the needs and cultural tradition of the community.

As part of a community-based agency which also provides a full range of primary medical care in a multi-service center, the Mental Health-Social Service Department is visible and easily accessible. Yet, visibility and easy access are concommitantly a benefit and a drawback. The drawback is that confidentiality becomes an issue, particularly given the social stigma attached to utilizing services which are other than educational and vocational services. This matter of confidentiality is addressed more extensively in sections on Staff Workshops, Intake Procedures, and Case Conferences.

A person's mental health rests with the resolution of intrafamilial value contradictions, conflict between divergent influences, and problems arising from racial discrimination. These conditions are best met in a therapeutic milieu which involves the following components:

a. short term therapy;
b. problem-centered therapy;
c. individual therapy (plus medication supervision when necessary); and
d. bicultural and bilingual staff providing services.

The most success occurred when a client herself had identified a single problem requiring services and the mental health staff helped her to resolve the problem.

Outreach education is of central importance. Crisis intervention and single-issue therapy can only address one factor in a person's life. They do not address underlying factors or issues. Outreach education

provides one way clients are able to receive treatment earlier. This project recognizes the need for the preventive model. Through this project, staff developed these competencies:

1. increased awareness of the services offered by QSCC Adult ESL:
2. ability to support Adult ESL staff through workshops and individual case consultations;
3. ability to integrate services provision with Adult ESL staff for students and clients using both programs; and
4. ability to understand the adult education program's methodology, particularly the role of advocacy.

TO CONSIDER - The Mental Health Staff

A. What is the composition of the staff?
B. What competencies does the staff currently have?
C. What competencies will this project develop or provide?
D. What is the role of the staff in this project?

PROJECT COMPONENTS

Once the staff involved in both programs are identified and desired objectives are defined, the planning continues. What follows are specific project components. These are:

A. Planning
B. Staff Training
C. Student Awareness
D. Referral Process
E. Intake Procedure
F. Case Conferences

A. Planning

The conceptual stages of this project began in early 1982. The director of Adult ESL approached the director of Mental Health Services to establish a model for systematic collaboration between both programs. The director of Mental Health had noted that clients simultaneously enrolled in Adult ESL classes showed faster therapeutic progress around issues of social and cultural maladjustment, alienation, isolation, and depression. This observation was also noted at the Cambridge Adult Learning Center and in discussion with other mental health workers in immigrant communities.

The recurring observation of increased therapeutic progress in adults concurrently enrolled in English classes led to development of this project. Implementation of a pilot project of systematic collaboration and distribution of our results through a manual could help other agencies, as well as our own, to provide such collaborations. However, the project was not without considerable difficulties. Some were anticipated and others were not. Some interesting results and several unexpected surprises were produced.

After the grant was received, both program directors met biweekly to finalize implementation, including workshop contents, referral process, and evaluation mechanisms. Staff of both programs provided continual input into the development of the project through staff meetings. The following chart shows the various phases of our project.

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Planning	----	----	----	----							
Staff Workshops		----	----	----							
Referral Process											
-planning		----	----	----	----	----	----	----			
-implementation			----	----	----	----	----	----	----	----	----
Case Consultation				----	----	----	----	----	----	----	----
Class Presentations					----						
Student Followup			----	----	----	----	X	X	X	X	X
Project Staff Meetings		X		X			X		X	X	X
Evaluation											
-process	----	----	----	----	----	----	----	----	----	----	----
-project					----		----			----	

TO CONSIDER - Planning

A. Who are the people from both agencies who are mainly responsible for the project?

B. How can staff and student input be provided?

C. How can measurable objectives for all participants be established?

D. What are the project components and what is the timeline for the project?

E. Which staff members are responsible for various components?

F. How can activities or components for achieving objectives be determined?

G. Is project reflective of goals and philosophy of participating agencies?

H. Are joint staff meetings established prior to project initiation and throughout project period?

B. Workshops

Staff workshops were the first part of the project to be implemented. They were completed before the referral process began. Workshops were

held on Saturday mornings, as it was the only large block of time available to all staff. All workshops were paid staff time.

Both program directors met and designed the workshop sequence with staff input. Workshops were presented by Mental Health staff; all Adult ESL staff participated. The three topics - each presented in two 3-hour sessions - were:

1 & 2. "Cultural Awareness"
3 & 4. "Psychopathology Among Asian Immigrants and Refugees"
5 & 6. "Mental Health Intervention and Referral"

The sequence progresses from general community issues to mental health issues and, finally, to the practical application of referral.

Workshops were structured to include: (1) a survey taken by Adult ESL staff; (2) topic discussion; (3) feedback from first session with suggestions for changes/modifications in the second session; (4) short summary at beginning of second session; (5) continued presentation; (6) conclusion; and (7) informal evaluation. The survey or questionnaire was used as a point of departure for each presentation and as an informal evaluation tool. The format of the six workshops varied from informal discussion to formal presentation. Current case studies were brought up by both staffs.

The following sections summarize the material covered in each topic area.

"Cultural Awareness"

Workshop Outline

I. Basic Differences in Philosophy of Life and Social Values of American and Chinese Culture

II. Background and Social System of Client Population's Place of Origin

III. Current Social Functioning in Daily Life

- A. Job
- B. Housing
- C. Recreational activities
- D. Social relationships
- E. Problem solving & emotional reactions
- F. Other issues of functioning in present social system

IV. Your Client in Role of ESL Student

- A. Traditional concept and philosophy of education
- B. Role expectation of teacher
- C. Expectations of clients as students
- D. Learning patterns
- E. Confidence in studies and emotional reactions to academic achievement
- F. Teaching strategies
- G. Fitting into the ESL program as a social system

V. Your Client in the Role of Spouse

- A. Marriage styles in the Chinese community
- B. Role of the female and and male partner at home
- C. Marital relationships and communication patterns
- D. Roles of the in-laws

VI. Your Client in the Role of Partner

- A. Parents' relationships pre-school aged children
- B. Parents' relationships with school-age children
- C. Parents' relationships with teenagers
- D. Differences in adjustment levels of parents and children

This workshop was presented by Phoebe Pao, Staff Psychologist and Coordinator of the Child Mental Health Team. The information presented in this workshop formed the springboard for the next two workshops, and it provided a composite picture of the adult student in her community and family structure. It also created a forum for sharing information and experiences and airing different opinions.

It was pointed out that learning English often affects a woman's role in the family. Among the results of learning English are: developing new peer support, developing survival skills faster, and understanding

their English speaking children. These achievements, however, also threaten and place strain on traditional family relationships.

Major points made in these two sessions were:

1. The value placed on education varies with different adult backgrounds.
2. An adult student's self-confidence affects her rate and method of learning.
3. Students from varying educational and cultural backgrounds respond differently to the program structure.

Evaluation of Cultural Awareness Workshops

Although initially seen as repetitive in terms of content, these sessions set the tone for understanding attitudes and perspectives of the adult ethnic Chinese student. They also provided an important forum for airing different perspectives of project staff.

This set of workshops should be included in future projects with one alteration: that the second part of this workshop be focused on how specific services provided by the Mental Health and Social Services department and by the Adult ESL program may address the cultural and immigration issues of their clients or students.

"Common Issues in Psychopathology Among Asian Immigrants"

Workshop Outline

I. Commonalities Among Asian Immigrants

A. Refugee experience
B. Adjustment experience
C. Cultural differences from American culture
D. Socio-economic factors
E. Cross-generational differences
F. High stress load

II. Common Problems and Psychopathology Among Asian Immigrants

A. Depression - symptoms
1. weight loss/gain
2. sleeping disturbances
3. loss of energy, interests
4. crying, upset
5. withdrawal
6. physical complaints (headache, stomachache, back pains)

B. Anxiety - symptoms
1. fearfulness
2. phobias, e.g. agoraphobia
3. tensions, worries
4. hyperactivity or inactivity
5. hypertension (high blood pressure)

C. Psychosomatic problems - symptoms
1. neck, back pains
2. ulcers
3. high blood pressure
4. headaches, stomachaches, etc.
5. diabetes

D. Psychosis - examples
1. disorientation
2. thought disorders
3. affective disorders
4. poor reality testing
5. unable to function "normally"

E. Paranoia - symptoms
1. extreme fearfulness
2. extreme suspicion
3. withdrawal
4. anger-hostility

F. Passive-aggressive behavior
1. tardiness
2. withholding
3. indirect means of expressing anger

G. Gambling
1. Example of obsessive-compulsive behavior
2. Self-destructive
3. Socio-economic stress
4. Cause of marital difficulties

H. Substance abuse
1. Alcohol
2. Other drugs and abuse

I. Marital conflicts
1. Different status of woman and men
2. Work patterns
3. Sexual problems in marriage
4. Extended families - in-laws, etc.

III. Marginality/Invisibility of Asians in American Society

A. Media stereotypes
B. Alienation, isolation
C. Loss of identity

IV. Intervention

A. How to talk to your students about problems
B. When to get involved and when to refer
C. How to set limits as a teacher-advocate
D. How to help adult students to help each other
E. How teacher-advocates help each other

V. Psychological Profiles

VI. Summary, Recommendations

This second set of workshops was presented by Connie Chan, Staff Psychologist. Building from the framework of the first two workshops which addressed the family and community role of Chinese immigrants, these next two workshops addressed the social adjustment issues which confront the Chinese immigrant and the ways in which these issues are often manifested.

Within a week after the workshop, its usefulness was demonstrated. A student on separate occasions exhibited two types of disruptive behavior: (1) outbursts of excited, loud talking and (2) falling asleep during class. Applying information from the workshops, the teacher-advocate found the falling asleep to be a symptom of new medication that needed to be adjusted. The excitement and excessive talking was also examined with some suspicion of a health-related cause. This behavior was found to be the result of the woman's getting a new, competitive job. This case illustrates that amateur diagnosis can be valuable but must maintain a common perspective.

These workshops provided a framework for the ESL staff to understand specific and characteristic behavior exhibited by students in class. Major points made in these workshops were:

1. Depression, a common response to the effects of immigration, often occurs between six and twelve months after immigrating.
2. The Adult ESL program provides a structured, constant environment for students.
3. Support systems outside of the family often begin in ESL classes.

4. Students should be encouraged to utilize their own support systems.
5. A person on medication may exhibit visible side effects such sleepiness, trembling, altered speech patterns, etc.

Evaluation of "Psychopathology Among Asian Immigrants" Workshop

These workshops provided new information for teacher-advocates by naming various behaviors they had observed and by noting the various stress factors encountered by students. It also provided a forum for teacher-advocates to share various observations of students with mental health professionals. These workshops are essential, but must be combined with ongoing discussions, i.e., case conferences, lest "amateur diagnosticians" abound.

"Mental Health Intervention and Referral"

Workshop Outline

I. Concept of Mental Health

II. Theoretical Framework of Transplantation

III. How to identify problems - observation, assessment and diagnosis

1. Cultural considerations
   a. Ethnic group of client (Chinese ethnic, Hong Kong, PRC, Vietnam, Laotian, Hmong, Cambodian)
   b. Time of arrival (acculturation factors)
   c. Age of client (generation; young single, adult or married)
   d. Past history, education and employment
   e. Circumstances surrounding departure of client and separation from loved ones
   f. Presence or absence of extended family, community support systems

IV. Who intervenes and How

V. When it is necessary to refer

1. For psychotic behavior
2. For marital problems
3. For socialization problems
4. For problems considered a major life event - socio-cultural transplantation is the summation of a cluster of events, not the specific symptom, but the magnitude of life change events; related to the onset of health changes

VI. Programs you can set up

1. Cultural awareness training
2. Training of students for future employment in social service
3. Developing linkages between Indo-Chinese community and local mental health facility

VII. Utilization

1. Appropriateness of therapy for family, community, etc.
2. Service delivery system

VIII. Successful mental health

IX. Confidentiality and role of teacher-advocates with mental health staff/other members in family system

The third and final series of workshops was presented by Jennie Yee, staff psychologist. These workshops dealt with the process and method of intervention when referral is appropriate. It specifically covered: various forms of intervention; how referral is made; what services are available at the Health Center; and how student confidentiality

can be assured.

These workshops were the "nuts and bolts" necessary for such a collaborative project. Not only did they help clarify referral and the integrated service plan, they also addressed the sensitive area of confidentiality.

As advocates, teachers help students in survival and cultural adjustment issues. This is part of their job and an important component for the success of the program. Yet, there are times when the teacher-advocate cannot continue in her role as advocate. There are many reasons: (1) the Adult ESL staff do not have the skills to address the student's needs; (2) there are too many needs to be addressed solely by the teacher-advocate; (3) an issue with one student is overly time-consuming. Limit setting by staff was a recurring theme which posed difficult problems.

As noted, confidentiality was an important concern. How should one approach a student who is experiencing problems? Once the approach is made and referral seems appropriate, how should one introduce the student to, in this case, the mental health team? In approaching students, the staff were concerned about how to initiate dialogue without offending the student. The time constraints of the program provide little time to sit down with a student and approach referral delicately. Some suggestions which evolved were: the direct approach (suggest a student see a mental health worker); referring somatic problems to the medical unit (because staff in the medical unit are trained to make relevant referrals to the mental health team); and recommending referral after addressing program-centered symptoms (attendance, class behavior). The discussion on referral initiated an exchange which would continue through project staff and program staff meetings, case conferences, and evaluations.

Evaluation of "Intervention and Referral" Workshops

This workshop was useful as it focused attention on two themes. It pointed out that the range and diversity of intervention require critical thinking and reinforced that there was no one method or approach in mental health provision. The first session effectively combined the content of the previous workshops to demonstrate how the Adult ESL staff, relying on personal knowledge, could determine their own course of action. The second session explored several methods of intervention, utilizing case studies provided by the staff.

These workshops are essential to applying all workshop information. The final workshop on referral should be held approximately five weeks into the project to provide time for discussion of issues encountered during referrals.

TO CONSIDER - Workshops

A. Determine sequence and approach. Although outline contents are Chinese-specific, their format is adaptable with some modification.
B. First workshop should be presented by representatives from both agencies. This sets the project as a joint venture and presents each program perspective on the adult population.
C. Determine who presents individual workshops.
D. Survey project staff for workshop content ideas.
E. Evaluate each workshop and the overall series.
F. Identify other forums for staff training such as program and project meetings.

C. Student Awareness

Staff of both programs provided information to students and clients about each other's services. This was done through the standard method of displaying brochures in the mental health department and developing an integrated plan for mental health clients to learn about the Adult ESL program. Both these standard forms of outreach were useful for program exposure, but class presentations where a mental health staff person talked to a class proved more successful.

Initially Adult ESL students were to be informed during school registration of the services available at the mental health center. However, since registration is a time consuming individualized process, it was decided that mental health staff would make presentations to the classes. This format proved important as it allowed difficult material to be presented in an environment comfortable and familiar to the students.

Before each talk, students were asked to fill out the following questionnaire on mental health issues.

Student Questionnaire

1.	Mental Health is as important as physical health.	True	False
2.	"Counseling" means "helping."	True	False
3.	Psychological counseling can also help us to deal with problems in our lives, marriage, education, and emotional adjustment.	True	False
4.	Psychological counseling is one of the ways to preserve our mental health.	True	False
5.	Only crazy people need psychological counseling.	True	False
6.	I don't know what mental health is.	True	False
7.	The South Cove Community Health Center has mental health services.	True	False

Students' responses revealed interesting information about their understanding of mental health issues. Approximately 93% of the 212 students

endorsed the first four statements as True. And yet the following questions (5, 6, 7) provided conflicting information.

Question 5 - 34% responded that only crazy people need psychological counseling.

Question 6 - 39% indicated that they never heard of mental hea.th.

Question 7 - 33% responded that they didn't know SCCHC had mental health services.

In other words, while these students know that mental health is something important (question 1), they do not know exactly what mental health is (question 6). Furthermore, while they know that psychological counseling is useful in many ways (questions 2, 3, 4), they still hold the stereotype that counseling is only for the seriously disturbed (question 5). The number of students who did not know that SCCHC has mental health services was actually higher than the 33% recorded. Quite a few students indicated that they didn't know the health center had such services but guessed the correct answer since a speaker from the health center was giving a talk on mental health services. Thus presentations were important to clarify ideas about mental health services and to identify the health center as a place where such services can be obtained.

Class presentations lasted approximately 30 minutes. Some presentations were short informative talks while others used regular classroom procedures (in higher level classes) to introduce English words around mental health. They all included the questionnaire, talking about services at the health center, and various issues that a person might bring to the health center.

One measure of the effectiveness of the Mental Health talk to the Adult ESL students is whether it affects the willingness of the students to seek mental health services when the need arises. The following two

cases are illustrations of this point:

Tom is a 3½ year old child referred to the mental health center by his day care teachers. His problems included difficulties in relating with other children and inappropriate behaviors in school. His mother, an Adult ESL student, was resistant to the day care staff's suggestion to seek psychological intervention. When initial contact was finally made, the intake worker had to alleviate her concerns by explaining the nature of mental health services. Realizing she was an Adult ESL student, the worker reminded her of the class presentations. At this point, the mother opened up considerably and indicated that she was willing to seek help for her child. The child is currently being seen at the health center.

Sue is a 21 year old Adult ESL student. Recently, her husband was seriously injured in a car accident.

> Aware that Sue had no relatives and minimal financial resources, her friends were concerned and suggested that she go to the health center to file for welfare. She did not request psychological counseling. However, when the intake worker suggested supportive counseling to deal with the crisis of her husband and welfare, she was receptive. In fact, she remembered the worker as one of the persons giving talks to classes on mental health. She is still a regular client.

Both of these cases point to the success of the class presentations. It made smoother the process of introducing a student to mental health services.

Class presentations proved effective for other reasons too. Students in ESL classes come to learn English. These time slots are valuable as they have many time constraints - work, children, family responsibilities. A talk in Cantonese about service availability is not what they come to class for. However, presented as a method of increasing English vocabulary and understanding basic mental health concepts the information can be part of their education process. In classes where the latter approach was used, more students asked questions of the mental health person and the teacher-advocate.

In addition to the class presentations, one class was selected to have regular in-class discussions of mental health issues once a month. This was a time to discuss issues confronting the students, such as parenting, school issues, and job related issues. What was generated was a support group among the students, facilitated by the mental health worker. Another non-class meeting was held to discuss issues in further depth. This was scheduled on Friday at the same time as regular classes met Monday through Thursday.

At first 5 students out of 22 remained. Discussion was informal and mostly for getting acquainted. At the next meeting, 11 students remained. Over the next sessions, numbers ranged from 9 to 15. Friday sessions were consistently smaller with 5 to 9 adults. Although some students voiced objection to using class time for non-English activities, attendance and participation by students in these discussions proved worthwhile. Both the class time and Friday sessions involved experience and information sharing. Peer support was fostered through the mental health worker's facilitation.

Evaluation of Student Awareness

Class presentations and the special ongoing support groups proved to be ice-breakers for both students and Adult ESL staff. It was often used as an introduction to discussing referrals to the health center.

The most valuable tool for increasing student awareness was the class presentations made by the Mental Health team. Coming to the classroom, the team presented difficult issues to the students in a safe and supportive environment with peer support. Styles of presentation ranged from a monologue presentation to vocabulary building. The latter method elicited far more student responses and questions. This method also enhanced acceptance, since students did not see the presentation as taking away their class time but as part of it.

TO CONSIDER - Student Awareness

A. Determine methods of informing students about collaboration.
B. Establish guidelines for class presentations by Mental Health staff. Have material presented in format which complements the adult education program.
C. Adult education staff should be aware of content to be coveyed prior to presentation.
D. Develop mental health oriented lessons as part of curriculum.

E. Establish in one class an ongoing discussion of issues confronting students for a pilot program.

D. The Referral Process

1. Referrals from the Mental Health Team to Adult ESL

Even though there is a waiting period of 6-18 months for Adult ESL, the Mental Health team was allowed ten priority slots for referrals. To explain the presence of these new students while maintaining confidentiality, the following letter in Chinese was distributed and then read by teachers at the beginning of the semester.

> As you know, the Qunicy School Community Council's Adult English as a Second Language Program has a long waiting list for our classes. Right now over 350 people are waiting for classes. When we have spaces in classes or when we open new classes, we give spaces to the people who signed up the earliest. We do not let people jump to the head of the list for any reason.
>
> However, two years ago we had to make an exception. At that time the government gave us money but required that we give preference to Southeast Asian refugees.
>
> This year we will have to make a few exceptions again. We received a special government grant which helps us to maintain our classes and services. To receive this grant, we are required to give approximately ten students priority in getting into the classes this year.
>
> Therefore, if during the year, you know that someone has gotten into a class faster than another person, it is not because of favoritism, special favors or back doors. It is because the government required us to give ten priority spaces this year. No additional priority spaces will be given and not more than ten will be given during the year. In all other cases we will continue as we have for the past six years - whoever registers the earliest gets in the earliest.

Referral to the Adult ESL program did not guarantee placement in class. Mental Health providers informed their clients of this fact and explained to them the registration process and other pertinent program information. This helped to facilitate student referrals without falsely raising the clients' expectations.

Initially, mental health center referrals were to be a part of the regular weekly registration period. Frequently, however, referred students who were expected to register didn't show. These no-shows were attributed to low self-esteem, poor self-confidence, and a lack of skills in time organization. Since this was an important step for clients who often had learning English as one of their self-defined goals, clients subsequently were personally escorted by the mental health provider. Registration was taken by any available ESL staff member, not necessarily during the registration period.

The following two examples are representative of successful referrals and the variety of issues confronting students. It is important to note,

however, that most students have not had nor will have psychotic episodes.

> June, a 31 year old married woman, has had schizophrenia since age 19 and was hospitalized in China and Hong Kong prior to her coming to Boston in May, 1980. Since coming to Boston, she has had two hospitalizations and was discharged in February, 1982. Since then she has been seen regularly for psychotherapy and medication supervision at the mental health center. Treatment goals include: (1) stabilizing her in the community; (2) supporting her parenting skills with her daughter who was placed in a foster home during her hospitalization; (3) placement of her son in a day care center to learn socialization; (4) placement of June in a sheltered workshop in order to gain self-esteem and confidence; and (5) learning English. June was placed in the Adult ESL program in January, 1983 and has been attending regularly. This is the second program she has undertaken. June expressed that she is happy in the Adult ESL program and is comfortable with her progress although she has not been a fast learner.

> Barry, a 24 year old man from Vietnam, had his first psychotic break in Hong Kong in 1980, and subsequently in Washington, D.C., and Boston. He was discharged in July, 1982, and has since maintained a stable condition in the community. Barry had a seventh grade education in Vietnam. He was a farmer prior to his escape to China and Hong Kong. His family remained in China. Living in Boston with his friends from Vietnam, he was homesick and felt hopeless about his future. He is being encouraged to better himself, with the ESL program as one of the tools toward this end. He continues to need a great deal of support and motivation to attend school.

Clients referred to the Adult ESL program were informed that their

teachers would be aware that the student was receiving support services from the mental health center. They were also informed that the mental health provider and the teacher would meet to talk about their classroom performance. All students who were referred agreed to this procedure. One teacher-advocate noted that in at least one case this knowledge of the occasional discussions fostered the student's trust in the teacher faster than with most other new students.

The following guidelines were established for referrals to the Adult ESL program from the mental health department.

1. Placement of clients referred to Adult ESL is not guaranteed.
2. Priority did not guarantee immediate placement as noted above; client's availability and available class times must match; and referrals should be dispersed throughout the classes as much as possible.
3. Teacher-advocates should be aware of students receiving mental health services being placed in class.

2. Referrals from Adult ESL to Mental Health Team

Six referrals were made to the Health Center by the Adult ESL staff. Initially, students didn't follow through on referrals and make an appointment; subsequently students were escorted by ESL staff. Each of the six referred students was seen by a Health Center staff person within two days. When a teacher-advocate discussed with a student options for dealing with a particular (or combination of) situation(s), the option to talk with a person from the mental health department was offered. Teacher-advocates or the Adult ESL counselor discussed the variety of services offered by the mental health department. A common point of departure was discussing the Health Center's "newcomer" groups of which many students were aware. Other students sought medical help for somatic symptoms. Two of the three cases who sought medical help eventually saw a therapist.

Some students who were successfully referred also realized that their support systems were strained. For example:

> Judy, a 30 year old married woman from China, has been hospitalized four times for surgery and chemotherapy over the last six months. During this period she has been a student in the advanced ESL class. Her teacher provided support and explanations of the various procedures she had to undergo during hospitilization. Other students visited her. Judy was referred to the mental health department for supportive therapy and crisis intervention.

This is an example of the combined efforts of the teacher as advocate, the mental health worker, and supportive peers.

Confidentiality was a concern for the Adult ESL staff. Whether a referral was made or the teacher was acting as an advocate, there were three important points in maintaining confidentiality: (1) other students should not know that the student was going to the mental health team; (2) instances of referral should be discussed only with other staff in meetings and with paired mental health workers; (3) information shared prior to a successful referral would not come out unless shared by the student.

In most cases, once referral was initiated, a student's introduction to the mental health services went smoothly. It was the discussion to determine whether referral was appropriate that was difficult for the staff. Most referrals were made when the teacher-advocate's limits and resources had already been approached or exceeded.

Evaluation of The Referral Process

Personal escort by staff was the most effective means for immediate referrals. Also useful was a "combined entry" into mental health services: if direct referral wasn't actualized, referral to medical care was made

and referral to mental health occurred from there.

Eight referrals from the Health Center to the Adult ESL program and six referrals from the Adult ESL program to the Health Center were made. Additionally, six students sought mental health team support and during intake mentioned that it was the class presentations which facilitated their coming.

What happened to the students?

* Tom's mother (p. 23), who was reluctant to have her son seen by the mental health staff, opened up considerably after being reminded of the class presentations. She is having her son seen by the mental health staff and is involved in family therapy as well.

* Sue (pp. 23-24) continues to be a client at the mental health center to help her deal with her husband's injury and her feelings about being on welfare. She attends classes regularly and has expressed that classes are her support throughout her ordeals.

* June (p. 28), referred by the mental health staff to Adult ESL, is regularly in both programs. Her teacher-advocate notes that June, although not a fast learner, regularly attends classes, has her homework done on time, and is contributing more in class.

* Barry (p. 28) continues to come to class and performs homework assignments periodically. He continues to need support for his English, yet he is showing signs of improving. He is interacting more with other students and Adult ESL is becoming a support system for him. As the semester break approaches, there is some concern that he may not come back.

* Judy (p. 30), the woman with cancer, is still a student with the program. Her attendance is sporadic due to chemotherapy, but when she can attend classes, she is there. Other students in the class are

supportive of her and her situation.

The major difficulty was inappropriate referrals from the Health Center. In order to assure that referrals are appropriate, mental health staff needs a clear understanding of what is required of students participating in Adult ESL classes.

TO CONSIDER - Referral Process

A. Establish priority system within each program.
B. Establish referral process; clarify what types of cases should be referred; determine whether there should be prior discussion between staff doing referral; determine whether personal escort should be provided.
C. If referral is made but not completed, what are the follow-up steps?
D. How do programs keep track of the number of referrals made and the result?

E. Intake Process

Once a student has agreed to see a mental health worker, she must go through an intake procedure at the Health Center. Before an initial appointment is made with a member of the mental health team, the prospective client meets with a mental health worker on call. The majority of referrals are escorted by a teacher-advocate who stays throughout intake to give the student support and make the transition smoother. At this time, general information about the student is taken and an appointment is given within two days.

The intake worker presents a summary of intake to the mental health team. Input is solicited and it is determined who will be assigned to the student. Assignment is determined by staff caseload, students' needs, and, when possible, with input from the teacher-advocate.

Diagnostic testing is not necessary for all referrals from the Adult ESL staff. The client's initial interview with the assigned mental health

worker determines the client's needs and available support services. After the second or third meeting, the client and mental health worker establish a plan of action. It includes goals and action steps which are addressed at each session; comments on progress and any changes are also noted.

All eight referrals made to the Mental Health Center were treated by problem-centered individual therapy with no medication administered. Most were short-term, averaging six sessions.

During the second or third session, students were asked if information could be shared with the teacher-advocate if matters pertained to class performance. This occurred in three situations and all three students agreed. At the conclusion of this project, two students are still in therapy.

TO CONSIDER - Intake Process

A. Each program's staff should be made aware of the intake procedures at both agencies.

B. Staff initiating referral should inform the student of the nature of this process.

C. What fees, if any, are involved in the referral process?

F. Case Conferences

Case conferences were held biweekly between the Adult ESL teacher-advocate and the designated mental health provider. They averaged an hour per session. Originally, this time was designated for "resource sharing, supportive case management plans, and follow-up." The following also occurred: supervision for the teacher-advocate, discussion of group dynamics, mutual feedback between team members, and discussion of particular students.

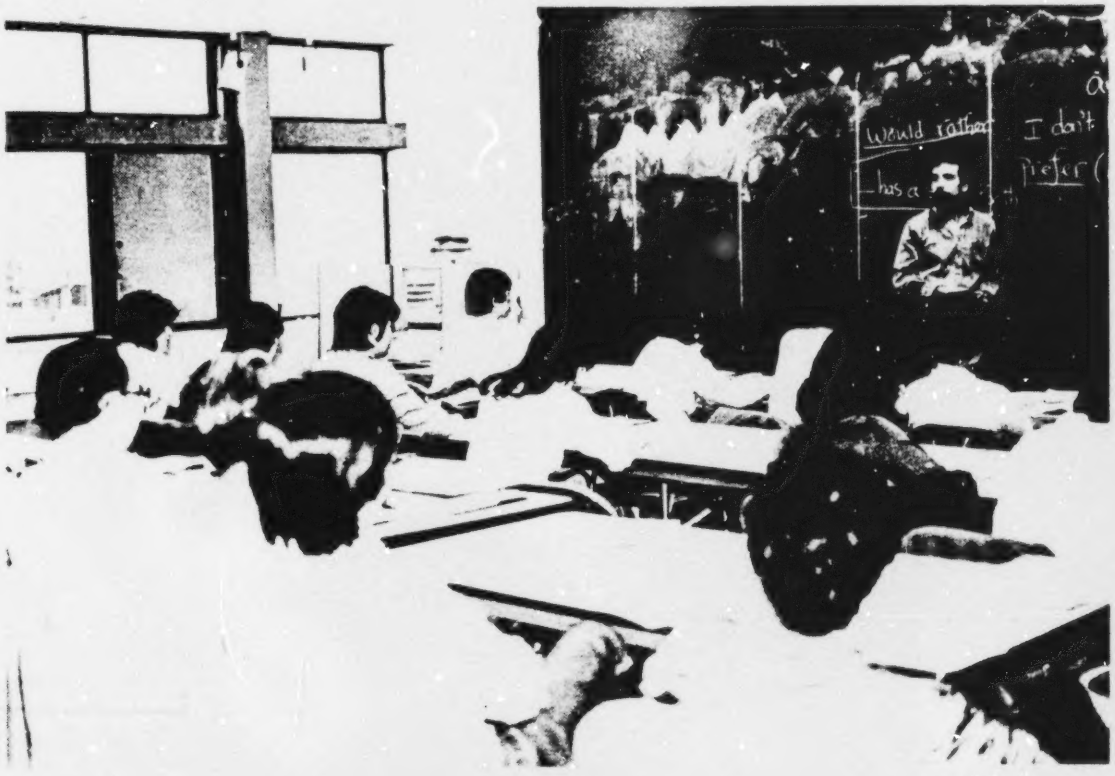
This provided an important forum for exchanges between the teacher-advocate and mental health worker. In one case, a woman referred to Adult ESL through the Health Center would not answer any questions in class and didn't participate in any oral drills. The teacher-advocate was frustrated, for he felt the student wasn't getting anything out of class. During consultation, when the teacher-advocate brought this up, the mental health worker provided evidence to the contrary. In therapy sessions, the student brought questions to the mental health worker about what she had learned, spoke positively about the classes, and was showing evidence of using English in everyday life. This feedback was crucial for the teacher.

In another instance, the teacher-advocate mentioned that a referred student might be having difficulty in class. When the teacher asked her questions, other students laughed at her response and sometimes at her failure to respond. At times, this student appeared very excited; at other times, she would fall asleep. Discussion with the mental health provider revealed the following: the student had mentioned students laughing

when she answered questions, but didn't have any negative feelings toward her classmates; in fact, she tended to laugh along with them. Her excitement was due to the fact that she had just gotten a job at a new market in Chinatown in spite of heavy competition. As for her falling asleep, the medication she was using needed to be adjusted. In this instance, feedback was important for both the teacher and the mental health provider.

Sharing information through the case conference format helped to lay the basis for understanding a particular student and developing a plan of action. Two types of action plans were used. The student plan was developed by the student and mental health worker with input from the teacher-advocate. For purposes of staff development, a second plan for the teacher-advocate included such issues as limit setting.

Plans for students were shared among team members for continuous feedback. These included: (1) observing a student for two weeks in class;



(2) deciding on methods of reinforcement; (3) providing feedback for the student; and (4) measuring the student's progress.

Observation provided the following information: the student's adjustment to classroom situations, including relationships with other students and the teacher; the student's participation in classroom exercises, attendance, and homework.

Reinforcement focused on a variety of issues. How should attendance be addressed and by whom (teacher-advocate, mental health provider, or both)? If a student was not able to answer a question, should simpler ones be given, or none at all for a while? How can positive classroom behaviors be supported?

In some cases the teacher-advocate needed information about the student's background to avoid embarrassing situations in classroom drills. Questions such as "How old is your father?" could revive painful memories if, for example, family members had been killed in the war.

The case conferences also dealt with teacher-advocates and their demanding role in the program, developing ways of dealing with job related issues such as guilt for referring a student, dealing with student crushes, and overextension. Also discussed were indirect issues which influence staff work performance and attitude, such as time commitment and other jobs. Case conferences address these issues while providing support for developing advocacy and referral competencies to handle situations in a preventive manner.

As mentioned earlier, the teacher-advocate is often one of the first bilingual/bicultural adults with whom the student has consistent interaction. The teacher-advocates become role models. Often, crushes between students and their teachers develop. Case conferences in these confusing and stressful situations allow frank discussion about limit setting, respon-

sibility, and appropriate relationships. The mental health staff's feedback and objective viewpoint on these sometimes delicate emotional situations is extremely valuable for the teacher-advocate. Candid dialogue between the mental health worker and the teacher-advocate, promoted by their ongoing collaborative relationship, results in a clearer perspective and practical suggestions about appropriate in and out of classroom behavior.

One student taxed advocacy services beyond the expectations and limits of the Adult ESL staff. The student was in the process of a difficult divorce and elicited support from ESL staff totaling over ten hours a week. She utilized both the Adult ESL counselor, her present teacher, and past teachers - four people in all. ESL staff decided to suggest referral to the mental health department. This was effectively made. Currently the staff are not spending the majority of their advocacy with one student. The student sees the therapist, but continues to seek support from the Adult ESL staff. Staff remain supportive but effectively set limits with the student and remind her to discuss issues with her therapist.

Evaluation of Case Conference

Biweekly one-on-one meetings between teacher-advocate and mental health staff members were well received by all participants. These meetings proved to be a source of support for the teachers as advocates, wherein various methods of advocacy could be discussed. They were also a source of feedback for the mental health staff with respect to referrals they had made.

In discussing personal limit setting and an individual teacher's role with students, some teachers were uncomfortable with using case conference time for these issues. However, through joint project staff meetings and

learning that other case conference time was also being used to this end, they felt more comfortable. By the end of the project, ESL staff believed this time had improved their advocacy skills and they were able to deal with various student behavior in class.

All project staff indicated that a regular time for case conferences was valuable. Case conferences should serve as a forum for individual support, resource sharing, and developing an integrated service plan. However, it should also be emphasized that the conferences may include other topics mutually agreed upon by team members.

TO CONSIDER - Case Conferences

A. In the first project staff meeting, project coordinators should outline the nature of the case conference. Various uses of this time should be delineated, emphasizing that individual teams might develop new directions throughout the course of the project year.

B. Teams should be established. If teams don't work out for one reason or another, new teams should be provided.

C. Teams should schedule a regular weekly time and use it as necessary.

CONCLUSION

Collaborations at the community level are vital for several reasons:

a. They improve the quality of services students receive while reducing duplication of those services;
b. They provide comprehensive service delivery to the community; and
c. They provide a forum for resource sharing and staff training.

They also conserve energy resources and pool strengths in a time when funding for community agencies is tight. Collaborations cannot succeed without adequate planning, adequate staff, and adequate funding. As community-based agencies recognize the need for planned collaborations to address to our respective community needs, so must funding sources.

Effective collaboration requires: (a) mutual commitment by participating agencies; (b) staff commitment; (c) programs with compatible philosophies; (d) objectives which reflect the specific needs of the community; and (e) funds to accomplish the collaboration.

This model project had an immediate impact on our ability to provide community services. Mental health clients made faster therapeutic programs and adult education students learned in an increasingly suppertine environment. A particular long range value of this collaboration is in the opportunity for human service professionals to work together to improve preventive mental health services. We continue in our belief that planned collaborations among community-based agencies enable people in our communities to provide a better life for themselves.

* The Adult English as a Second Language Program is one of six programs offered by the Quincy School Community Council in Boston's Chinatown. For seven years, the Adult ESL program has assisted over 2,500 Asian immigrants in developing self-reliance and economic self-sufficiency through English as a Second Language instruction. The staff have designed a practical survival-oriented bilingual program in combination with bilingual counseling, tutoring and support services.

The Adult ESL program serves over 500 students in a five semester program focusing on conversational and written English, employment, consumer and life skills for new immigrants. The overall commitment is to meet the needs of the adult learner in a bilingual, bicultural and educationally supportive fashion.

* The Department of Mental Health and Social Services at the South Cove Community Health Center is part of the primary care services located in the same complex as the Quincy School Community Council. The mental health department provides culturally appropriate and relevant treatments to the Asian population of Greater Boston. Modification of conventional Western pyschiatric approaches and treatment modalities are provided by trained bilingual and bicultural professionals. The services include: therapy - long term, short term, individual, family, couple, group; psychological and diagnostic testing; case and family consultation; crisis intervention; home visits; mental retardation and development disabilities.

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